

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29C0001049		(X2) MULTIPLE CONSTRUCTION A. BUILDING 1A - THOMAS AND MACK MEDICA B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009	
NAME OF PROVIDER OR SUPPLIER SURGICAL ARTS CENTER, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9499 WEST CHARLESTON BLVD, #250 LAS VEGAS, NV 89117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 21794 This Statement of Deficiencies was generated as the result of a Medicare life safety code resurvey conducted at your facility on 12/22/09.</p> <p>Your facility was surveyed using Chapter 21, EXISTING Ambulatory Health Care Occupancies, and Chapter 39, EXISTING Business Occupancies of the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>There were no regulatory deficiencies cited during this survey. Please retain a copy of this survey for your records.</p>			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.